



# REPETITIVE TRAUMA QUESTIONNAIRE

Claimant's Name		Claim Number:	Injury Date / /
1. Condition for which claim was filed / /		3. While employed, did your symptoms interfere with your work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, How?	
2. When did you first notice you had a problem with your condition? / /			
4. When were you first told by a doctor that your condition was caused by your job? / /		5. Did you have any diagnostic studies? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Name & address of doctor who told you that your condition is occupational:		City	State ZIP + 4
7. Have you been examined by any other doctors for condition? <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, please provide:			
Name and address of doctor		Exam Date / /	
		/ /	
		/ /	

## HEALTH HISTORY

8. Do you have a health problem for which you must take medication and/or have treatment for on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, what is the health problem, and what kind of medication are you taking?			
9. Name of doctor prescribing your medication: Address City State ZIP + 4			
10. Have you had any injury to the same area for which this claim was filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe the injury:			
11. Have you had any illness that affected the same area for which this claim was filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe the illness:			

## FAMILY HISTORY

13. Name of your family's physician	Address	City	State ZIP + 4
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## NON-WORK EXPOSURE

14. Do you have any hobbies or non-work activities which involve repetitions to the area for which the claim was filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:	
15. Please list any other hobbies or activities you participate in:	